Building a Team: Caring for a Community

IMPROVING CARE THROUGH A CONTINUED PARTNERSHIP

OHIO HOSPITAL ASSOCIATION

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Presented by:

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Presentation Objectives:

▪ Explain the elements of the Community Quality Council

▪ Discuss regulatory, data, benchmarking and measuring outcomes

▪ Identify community resources that are of interest across the health care continuum
UC Health - West Chester Hospital

• New hospital opened in May 2009

• Located between Cincinnati and Dayton on the growing I-75 corridor

• 178 inpatient beds

• 40,000+ annual ED visits

• Initial focus was on internal hospital operations and processes
• Changing external environment
  • Affordable Care Act
  • Quality Scorecards
  • Value Based Purchasing

• Change equally pronounced in the post acute care space
  • Focus on Readmissions
  • CMS Bundled Payment Pilot (BPCI)
  • CCJR
Identified needs related to post acute care relationships:

- Develop relationships / contact points with post acute care partners
- Enhance communication with entities throughout the continuum of care
- Desire for consistent and continuous data exchange
- Provide updates on hospital/system initiatives
- Share learning on clinical best practices

Need to create a collaborative forum

- Vision is to provide the highest quality of care in our community
Building A Culture Beyond Business

- UC Health West Chester Hospital Community Quality Council first met in March 2013

- Initial invitation extended to approximately 15 area long term care facilities
  - Community Quality Council is currently comprised of eleven Post Acute Care providers
  - Hospital participants include Nursing, Case Management, Pharmacy, Quality, Social Work, ED, Infection Prevention and Physicians
UC Health - West Chester Hospital
Community Quality Council

• Steps to form the Council included:
  • Team building and learning
  • Assessment of what was important to each Council member’s organization
  • Frequent communication on the Council’s collaborative approach
  • Discussion about the Council’s priorities
  • Creation and approval of a Charter

• Goal was to break down barriers and build trust
UC Health - West Chester Hospital
Community Quality Council

• Council ground rules include:
  • Meet on a monthly basis
  • Each Council member organization can have one individual attend the meeting
  • Preference is for meeting participant to be from Nursing or Quality
  • Members vote as to whether or not to add additional members to the Council

• Desired a meeting environment that was collaborative and egalitarian, where every member’s voice would be heard
Collectively, these organizations care for 3,200+ individuals
Post Acute Care Perspectives

• Reaction to Initial Invitation
  • Apprehension
  • Back-door elimination process?
  • Competition present
  • “Be present and listen” thoughts
Post Acute Care Perspectives

- Post Acute Care Provider Goals / Evolution
  - Turned acquaintances into collaborators
  - Built relationships
  - Barriers fell
  - Our industry more understood
  - Care enhanced through sharing with each other
Building West Chester Hospital’s Post Acute Care Knowledge

Problem
Need Identified/Education

Member Discussion
Sharing of Best Practice

Implementation
Improved Customer Care
Enhanced Pharmacy Relationships

- Medications on hand
- IV medications protocols
- Sharing of industry updates
- Medication reconciliation
### Additional Topics Addressed

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<tr>
<th>Category</th>
<th>Topic</th>
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<td>DATA BENCHMARKING</td>
<td>VIDEO MONITORING</td>
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<td>COUNCIL ON AGING</td>
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<td>BUNDLED PAYMENTS</td>
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<td>GRAND ROUNDS</td>
<td>FALL PREVENTION</td>
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<td>BENCHMARKING</td>
<td>SCORE CARD</td>
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<td>NO PASS ZONE</td>
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<td>INFECTION PREVENTION</td>
<td>CRIME PREVENTION</td>
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Community Partner Presenters

- Butler County Health Department
- UC Health
- Council on Aging of SW Ohio
- Local Fire Department
- Local Police Department
- Pharmacy
- Hospice
- Catholic Charities
- University of Cincinnati School of Allied Health
Advanced Directives

• Problem
  • Members identified that readmissions to hospital often occur related to chronic, end stage illness

• Member Discussion
  • Palliative Care Program implemented at MKV was shared with other Council members

• Implementation
  • The Health Collaborative (Cincinnati) has initiated a community wide project including all participating hospitals and SNF’s to implement advanced care planning discussions using the MOLST format
  • Other member facilities have visited MKV to learn more about developing a palliative care program in their SNF
Transfers/Handoffs

• Problem
  • Information communicated to ER staff at time of transfer from post acute care provider was incomplete/inconsistent

• Member Discussion
  • ER physician attended Council meetings to describe type of information that was needed to heal patient efficiently and safely
  • Council members agreed that a standardized transfer document would enhance communication of information

• Implementation
  • Subcommittee formed to research and develop transfer document
  • Committee was presented INTERACT-4 Transfer Document
  • Implementation completed fall 2015
Access to Epic EMR System

• **Problem:**
  • The practice of faxing patient record and discharge information was inefficient

• **Member Discussion:**
  • Post acute care providers requested “read only” access to EMR in order to smoothly transition patient

• **Implementation:**
  • Working with individuals from Information Systems, Compliance, Legal and Clinical Documentation, “read only” access to UC Health’s Epic EMR system was made available to pertinent providers
Bundled Payments for Care Improvement (BPCI) Pilot

**Problem:**
- BPCI Model 3 participants needed DRG information of patients discharged from WCH to their facility

**Member Discussion:**
- Post acute care providers educated hospital staff
- Committee recommended that a hospital contact be designated to improve the process

**Implementation:**
- Implemented process that communicates patient “working” DRG information to SNF same day as requested and patient “final” DRG information two to three days later
Shared Practices: Improving Care

### Standardized Data Collection

- Must be easy to collect
- Clear definitions
- Examples of how to count

**BOTTOM LINE:** Must be apples to apples

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definitions</th>
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<tr>
<td>Readmission Rate within 30 days</td>
<td><strong>Numerator:</strong> total number of patients readmitted to all hospitals within 30 days of their admission date (including those within 7 days)</td>
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<td><strong>Denominator:</strong> total number of patients admitted from all hospitals.</td>
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<td><strong>Percentage</strong></td>
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<td><strong>Percentage</strong></td>
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<td>ER visits</td>
<td><strong>Numerator:</strong> total number of patients sent to ER within 7 days of their admission date</td>
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Readmissions

- **Problem:**
  - How to reduce patient readmissions

- **Member Discussion**
  - Barriers to preventing readmissions

- **Implementation:**
  - Representatives from PACs on our Readmission PI Team
  - Handoff tool – addressing topics such as progressive mobility
  - Risk tools in ER
  - Matrix of services and payors
  - Council on Aging – Care Transitions Program
  - The Health Collaborative – Advanced Care Planning
  - Med Reconciliation Program
Shared Practices: Improving Care

West Chester Hospital Readmission Rates for Patients Discharged to WCH Community Quality Council PACs

Total WCHCQC PAC Discharges = 3478
Ongoing Areas of Focus

- Readmissions
- Care Transitions
- Benchmarking
- Med Reconciliation Program
- Patient Safety
- Bundling and CJR
- Infection Prevention
In The Future

- Palliative Care
- Chaplains
- Home Health
- Consumer Member
- Patient Satisfaction
- Rotate Meeting Sites
Implementing a Quality Council in Your Community

• Suggestions:
  
  • Be inclusive of all post acute care providers
  
  • Allow time after the meeting for networking opportunities
  
  • Give members a voice
    • Voting system to include potential new members
    • Suggestions on educational topics of interest
### Challenges

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<th>Hospital</th>
<th>Post Acute Care Provider</th>
<th>Both</th>
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<tr>
<td>Two-way dialogue</td>
<td>Comfort level to share information</td>
<td>Building of trust</td>
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<tr>
<td>Relevant content</td>
<td>Lack of time for meeting</td>
<td>Confidentiality</td>
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<tr>
<td>Lack of PAC member participation</td>
<td>Relevant information</td>
<td>Common data terminology and definition</td>
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<tr>
<td>PAC member continuity</td>
<td>Unknown members</td>
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Implementing a Quality Council in Your Community

<table>
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<th>Benefits</th>
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<tbody>
<tr>
<td>Improving benchmarking capabilities</td>
<td>Networking and new collaborations</td>
<td>Building a foundation to make future improvements in healthcare</td>
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<tr>
<td>Knowledge of post acute care industry</td>
<td>Knowledge of hospital industry</td>
<td>Breakdown of barriers</td>
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<td>Efficient dissemination of information</td>
<td>Ad hoc information sharing</td>
<td>Improving patient safety</td>
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<td>Sharing resources</td>
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<td>Improving transitions of care</td>
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Play video
“From my perspective, this meeting has helped our pharmacy gain a better grasp of how to partner with our customers regarding:

1. The importance of individuality of medications to have on hand for nursing facilities to use for immediate need
2. The sharing of information regarding IV medication administration and protocols/industry standards
3. The sharing of general industry updates, such as the update in CDC pneumococcal vaccination protocol changes
4. The collaboration of the hospitals and long term care facilities and pharmacies regarding readmission prevention – medication reconciliation as an important component.”

   Lorinda Babb, PharmD, CGP, Clinical Manager, Omnicare

“As a result of attending the Council and the sharing of the readmission risk tools we will be trialing those tools and doing an official research study with our CHF population.”

   Cheryl Harris RN CCM, Utilization Review Manager, UC Health – WCH
“Participating in the council is a collaboration of health care professionals that – prior to didn’t share experiences or knowledge. By participating, I get the privilege of being part of a journey that is slowly changing the way different continuums of care communicate and serve our patients/residents for better outcomes.”

WCH Community Quality Council Survey Respondent

“Our patients are benefitting from improved transitions among different levels of care, especially because of the council's growing understanding of some inherent differences in our care settings.”

WCH Community Quality Council Survey Respondent
Contact Information

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